SPECIAL BULLETIN
(Dist: All providers)
Vol. 23, No. 3
August 23, 2000

Missouri MEDICAID Bulletin

www.dss.state.mo.us/dms

INDEX **PAGE**

NAME CHANGE

Effective August 1, 2000, the name of the fiscal agent for the Division of Medical Services changed to Verizon Data Services, Inc. This name change is the result of the merger between GTE and Bell Atlantic. All claims processing and other fiscal agent functions remain unchanged.

INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

Providers may now access information through the Interactive Voice Response (IVR) System. The IVR System has replaced the Audio Response Unit (ARU). All information previously supplied on the ARU is still available on the IVR. The IVR telephone number is (800)392-0938.

- The IVR offers primarily digitized voice recorded messages and a computer generated voice for pronunciation of proper names.
- Eligibility inquiries will provide the recipient name and core eligibility information. A new sub-menu structure will allow the caller to select additional information available for the recipient. The sub-menu options include:
    - lock-in and health plan information
    - eye exam and eyeglass information
    - TPL information
    - Medicare and QMB information
    - Medicaid ID, name, spelling of name
    - repeat of eligibility information
    - repeat of confirmation number
    - inquiry on another recipient
    - return to the main menu
    - end the call
    - transfer to a Correspondence and Information Specialist
- Providers will be given expanded explanations of claims adjudicated. The explanation is a description of the Explanation of Benefits (EOB) assigned to their claims.
- Inactive providers will be permitted to perform eligibility verifications for their patients if the dates of service on which they are inquiring fall within the time frame they were Medicaid enrolled providers.
- The IVR allows for troubleshooting and faster response time if system problems occur.
- Providers of all programs may access General Section 3 - Provider and Recipient Services for detailed instructions on the IVR system. Manuals and general sections are available to providers via the Internet at the Division of Medical Services web-site

<**www.dss.state.mo.us/dms**>.

VERIZON DATA SERVICES, INC. HELP DESK

The Verizon Data Services, Inc. Help Desk is available for use by providers billing electronically. The dedicated telephone number is (573) 635-3559. The responsibilities of the Help Desk include:

- Front line assistance to providers and billing staff in establishing required electronic claim formats for claim submissions and the Division of Medical Services developed billing software.

- Front line assistance accessibility to electronic claim submission for all providers via the Internet. Internet submission is discussed later in this bulletin.

- Front line assistance to MC+ Managed Care health plans and MC+

Fee-for-Service providers in establishing required electronic formats, network communications, and ongoing operations.

INTERNET ELECTRONIC CLAIM SUBMISSION AND ELIGIBILITY VERIFICATION

Effective in the fourth quarter of calendar year 2000, Missouri Medicaid will be expanding accessibility to electronic claim management technology for all providers via the Internet. The new web site address is <**www.emomed.com>.** Providers will be required to contact the Verizon Data Services, Inc. Help Desk at (573) 635-3559 to obtain authorization for Internet submissions by completing an Internet Security Agreement. For new providers, the Internet agreement will be included with their enrollment packet. Providers will be unable to access the new site without proper authorization. An authorization is required for each individual user. A user can be granted authorization for multiple providers and will only have access based authorization obtained when completing the Internet Security Agreement. The new Help Desk will also offer front line assistance for technical issues.

For full functionality of the new Internet application, a Web Browser of Internet Explorer 5.0 or higher or Netscape 4.7 or higher is recommended. The features of the new Internet application include claim submissions, claim attachment submissions, claim credits, prior authorization requests, and eligibility verification.

CLAIM SUBMISSION AND CREDITS

The following claim types can be used in Internet applications: Medical (NSF), Inpatient and Outpatient (UB92), Dental (ADA 1999, Version 2000), Nursing Home (FENIX) and Pharmacy (NCPDP). Medicare Part A and Medicare Part B Crossovers will be implemented with a future enhancement in May 2001, which will be addressed in a future bulletin. The field requirements and filing instructions are the same as those for paper claim submissions. For convenience, some of the input fields are set as indicators or accepted values in drop down boxes. Providers will have the option to input and submit claims individually or in a batch submission. A confirmation file will be returned for each transmission. The Internet will also offer the ability to submit individual claim credits only.

The following claim attachments are included in the May 2001 enhancement: Certificate of Medical Necessity, Second Surgical Opinion Form, Acknowledgment of Receipt of Hysterectomy Information, Sterilization Consent Form, Oxygen and Respiratory Equipment Medical Justification Form (OREMJ) and Medical Referral of Restricted Recipient (SURS 118).

ELIGIBILITY CLAIM STATUS AND VERIFICATION

For eligibility verification, the current inquiry options available through the Interactive Voice Response (IVR) System will be offered on the Internet, with the exception of Type of Service (TOS)/Procedure Code Inquiry. Functions include eligibility verification by: Recipient ID, Casehead ID and Child's Date of Birth; Social Security Number and Date of Birth; claim status; and check inquiry. Eligibility verification can be performed on an individual basis or as a batch submission. Individual eligibility verifications will occur in real-time similar to the IVR, which means a response will be returned immediately. Batch eligibility verifications will be returned to the user within twenty-four (24) hours.

REMITTANCE ADVICE

Providers will also have the capability to receive and download their Remittance Advice from the Internet. Access to this information is restricted to users with authorization. In addition to the Remittance Advice, the Explanation of Benefits Listing, Exception Listing and current fiscal year Claims Processing Schedule will be available on the Internet. The Internet site will be available twenty-four (24) hours a day, seven (7) days a week with the exception of scheduled maintenance.

All of the Internet screens offer on-line Help (both field and form level) relative to the current screen viewed by the user. The option to contact the Help Desk via E-Mail will be offered as well. As a reminder, the Help Desk is only responsible for the Internet Security Agreement and technical issues regarding electronic claim submissions. The user should contact the Provider Relations Communication Unit at (800) 392-0938 for assistance on Medicaid program related

issues.

ELECTRONIC NIGHTLY ADJUDICATION

Electronic claim submissions received prior to 5:00 p.m. Central standard time, on a daily basis, will be adjudicated on a nightly basis, Monday through Friday. Claims submissions received after the 5:00 p.m. cutoff will be adjudicated the following night. This is a change from the current weekly adjudication process. This new process will be performed on all claim types. The nightly adjudication will allow next day final claim status checking, quicker re-submission capability if a claim denies, and less congestion as remittance date cutoff approaches. Paper claims will continue to be adjudicated on a bi-weekly basis; Tuesday and Friday.

IMPORTANT: The financial cycles will continue to run twice a month with provider checks mailed generally on the 5th and 20th of the month.